



DEPARTMENT OF THE ARMY  
HEADQUARTERS, U. S. ARMY EUROPE REGIONAL MEDICAL COMMAND  
CMR 442  
APO AE 09042

REPLY TO  
ATTENTION OF:

MCEU

07 March 2003

MEMORANDUM FOR ERMCM Staff

SUBJECT: Policy No. 26, Civilian Fitness Program

1. References:

- a. AR 600-63, Army Health Promotion
- b. DA Message R 261625Z Mar 96, Subj: Civilian Health Promotion Programs

2. Purpose. This document outlines the support and participation for the civilian and local national population within the Europe Regional Medical Command to participate in the Civilian Fitness Program. The Commanding General supports and encourages our civilian workforce to participate in the Civilian Fitness Program. Work schedule adjustments will be made on a case by case basis to accommodate the participation in the Civilian Fitness Program.

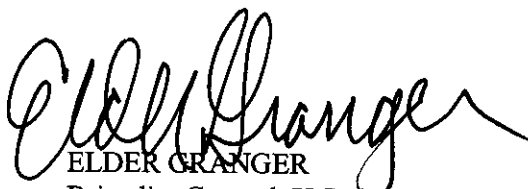
3. Responsibility. Civilians employed by the Army are encouraged to engage in a regular program of exercise and other positive health habits to improve and maintain a healthy lifestyle. This is an individual responsibility that is supported by this Command.

4. General. The ERMCM will approve up to three (3) hours excused absence per week to allow employees to participate in the initial command sponsored formal physical exercise training program. This training will include participation evaluation both pre and post program, continuous monitoring during the program, and nutritional education. These activities must be an integral part of a total fitness program and are limited to six (6) months in duration. The employees must complete a Civilian Fitness Program Packet. After the six (6) month program is complete and the civilian employee wants to continue their physical fitness program, the employee's work schedule will be adjusted to accommodate physical exercise training. These adjustments will be made when possible and consistent with workload and mission, with the understanding that a full eight (8) hour day will be worked. Employees will be required to submit a physical fitness plan to their direct supervisor.

5. The point of contact for this policy is MAJ Lopiccolo, Executive Officer, at 371-2190.

Encls

1. Civilian Fitness Program Packet
2. Civilian Fitness Program Information
3. Fitness Center Calendars

  
ELDER GRANGER  
Brigadier General, U.S. Army  
Commanding

# CIVILIAN FITNESS PROGRAM



## INITIAL FITNESS ASSESSMENT INSTRUCTIONS & CHECKLIST

Follow the instructions carefully to ensure that your file is set up properly. Complete these instructions **BEFORE ATTENDING** the initial Fitness Assessment.

1. Complete all of the documents in the Civilian Fitness Enrollment Packet.
  - a. You must have your **Supervisor's Signature** on the Civilian Fitness participation Agreement in order to enroll.
  - b. Be sure to complete the Civilian Fitness Participation Agreement to include:
    - Location of exercises (fitness center closest to your work place).
    - Include dates of program participation: **Spring Period:** 1 April to 30 September or **Fall Period:** 1 October to 31 March.
    - Days of the week and times agreed that the employee will exercise. Scheduling exercise at a regular time is key to program success.

2. **Set-up your CIV FIT Manila File Folder. The file must be complete in order to be assessed at your appointment.**

### **Assemble your folder in the following order:**

#### **Written on the Label Side of the Folder (for Filing):**

- \_\_\_ LAST NAME, FIRST NAME printed in CAPS
- \_\_\_ Program Start Date (example: 1 October then YEAR)

#### **Stapled on Inside Left of Manila File Folder:**

- \_\_\_ Completed Participation Agreement **signed by your supervisor and you.** – **Appendix B**

#### **Stapled on Inside Right of Manila File Folder:**

- \_\_\_ Fitness Assessment Form (You will receive this at your Fitness Assessment)
- \_\_\_ Completed Health History Questionnaire signed by you and reviewed by Assessment Staff (on top). – **Appendix C**
- \_\_\_ Completed Medical Considerations Form and Health Care Provider Approval – **Appendix D**
- \_\_\_ Signed Informed Consent – **Appendix E**
- \_\_\_ Health Care Provider Referral - **Appendix F**

#### **Stapled on Outside of Manila File Folder:**

- \_\_\_ Initial Fitness Assessment Instructions and Check List – **Appendix A**

3. Check off items on Initial Fitness Assessment Check List as you complete them.
4. Plan to attend one of the Civilian Fitness assessment times marketed in your community. Exit Assessments will occur simultaneously. No appointment necessary, participants seen on a walk-in basis. Contact your local POC for more information:

BSB	POC	PHONE
411 BSB / 26 ASG	Ms Steffanie Paoletti paolettis@26asg.heidelberg.army.mil	DSN 370-6489
293 BSB	Mr Theodus Green <a href="mailto:theodus.green@26asg.army.mil">theodus.green@26asg.army.mil</a>	DSN 385-2095
415 BSB	Mr Gerd Backhaus gerd.backhaus@hq.21tsc.army.mil	DSN 486-8713
233 BSB	Mr Jerry Davis davisjer@cmtymail.26asg.army.mil	DSN 348-7359/6281

5. Arrive at Civilian Fitness assessment dressed for light exercise.

*I certify the documents identified above are complete and accurate to the best of my knowledge. I understand that I will not be enrolled into Civilian Fitness Program if the checklist above is not complete.*

**Participant's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Supervisor's Signature** \_\_\_\_\_ **Date:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Agreement between Employee and Supervisor  
For Participation in the Civilian Physical Fitness Program**

*\*Make a copy for your records and return to your supervisor. You are not enrolled until you are medically cleared at the assessment or your supervisor receives the health care provider's approval form.*

Name of Employee: \_\_\_\_\_ E-mail: \_\_\_\_\_  
 APO Address: \_\_\_\_\_  
 Work phone: \_\_\_\_\_ FAX Number: \_\_\_\_\_  
 Name of Supervisor: \_\_\_\_\_ E-mail: \_\_\_\_\_

**AGREEMENT**

1. We understand and agree that (employee name) \_\_\_\_\_ will be participating in the Command-sponsored Civilian Fitness Program for 3 one-hour sessions each week for a total of 78 hours over a consecutive 6 month period beginning \_\_\_\_\_ and ending \_\_\_\_\_. We understand and agree that the specified exercise location will be the place of duty during authorized exercise periods, as follows: exercise periods will be on the following days of the week \_\_\_\_/\_\_\_\_/\_\_\_\_, at the following times \_\_\_\_\_ to \_\_\_\_\_, and at the following location \_\_\_\_\_.
2. We also understand and agree that:  
*The following may be individually amended or deleted according to the sponsoring Commander's guidance.*  
 ---Exercise days, times, and/or locations may be periodically amended only with prior approval of the supervisor, and amendment of this agreement.  
 ---Unused exercise hours may not be carried forward to subsequent weeks.  
 ---The program end date will not be extended to make up for exercise periods missed because of leave, TDY, or other reasons.  
 ---Exercise periods may be combined with only one of the following: morning break, afternoon break, lunch period.  
 ---No additional duty time is automatically authorized for pre-exercise preparation (e.g., changing clothes) prior to exercise periods, or for personal hygiene or "cooling down" following exercise periods.  
 ---Specified exercise periods may not be used for any non-duty purpose. Any period or portion thereof not used in actual fitness training and exercise will be spent in the normal duty workplace accomplishing normal duties.  
 ---Exercise periods are official duty time. Failure to appear, inappropriate use of exercise time, or misconduct during these periods would be considered as workplace infractions occurring during normal duty hours, and would be subject to the same disciplinary actions.
3. As a participant, I, the employee, will sign in and out from exercising at the gym or with my supervisor. I agree to file my goals and exercise routine in the file that will be kept by my supervisor. I understand that I must complete the post fitness assessment.
4. As a participant, I, the employee, understand that failure to complete the program, to include the exit assessment, will be at the discretion of the supervisor for denying the use of administrative leave for the time spent exercising and for changing the time and attendance records. Instead, the employee will be permitted to take annual leave or will be charged with Leave Without Pay in place of the administrative leave previously granted.
5. As a participant, I, the employee, understand that my signature below indicates that I have not participated in the Civilian Fitness Program at any other time prior to this current enrollment period.

Signature of Employee \_\_\_\_\_ Date \_\_\_\_\_

Signature of Supervisor \_\_\_\_\_ Date \_\_\_\_\_

**HEALTH HISTORY QUESTIONNAIRE**

1. Name \_\_\_\_\_ Unit/Dept/Sec \_\_\_\_\_
2. Work Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_
3. Sex (circle one): MALE FEMALE Age \_\_\_\_\_ Date of Birth \_\_\_\_\_
4. Person to Contact in Case of Emergency:  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_
5. Are you taking any medications or drugs? YES NO  
If yes, please list drugs (incl. supplements) \_\_\_\_\_  
Why do you take the drug? \_\_\_\_\_
6. Does your doctor know you are participating in an exercise program? YES NO
7. Do you currently participate in exercise regularly? YES NO  
If yes please describe your exercise activity: \_\_\_\_\_  
How many days per week? \_\_\_\_\_ How much time each time? \_\_\_\_\_
8. Do you have, or have you had any of the following (circle Yes or No to each):
 

a. History of heart problems, chest pain or stroke	YES	NO
b. High Blood Pressure.	YES	NO
c. Any chronic illness or condition	YES	NO
d. Difficulty with physical exercise	YES	NO
e. Advice from physician not to exercise.	YES	NO
f. Recent surgery (last 6 months).	YES	NO
g. Pregnancy (now or within last 3 months)	YES	NO
h. History of breathing or lung problems	YES	NO
i. Muscle, joint or back disorder, or any previous injury still affecting you.	YES	NO
j. Diabetes or thyroid condition	YES	NO
k. Obesity (more than 20 lbs over ideal body weight)	YES	NO
l. History of heart problems in your family (Parents, siblings, cousins)	YES	NO
9. Do you currently smoke or chew tobacco? YES NO  
If yes, # years \_\_\_\_\_ # cigarettes/cans per day \_\_\_\_\_

Please describe **Yes** answers and explain any other conditions that may limit exercise:

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Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Reviewed by \_\_\_\_\_ Date \_\_\_\_\_

**MEDICAL CONSIDERATIONS**

Before engaging in a moderate physical conditioning program, certain medical or health issues need to be addressed. This is especially important if you are over 40. Occasionally, diseases are present which the individual is unaware. This is often true in the beginning stages of cardiovascular (heart and blood vessel) disease — especially as an individual gets older. These undetected or “sub-clinical” diseases may cause problems when a vigorous exercise program is begun.

Ask yourself these key questions to see if you should get a medical screening:

- | <u>YES</u>               | <u>NO</u>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Has your doctor ever said you have heart trouble or high blood pressure?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Do you have chest pain while exercising or any other time?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you lose your balance or lose consciousness as a result of dizziness?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you become extremely short of breath with mild exercise/exertion?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you feel frequent skipped heartbeats?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Do you ever experience blurred vision while exercising?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Do you have a muscle/bone/joint problem aggravated by physical activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Are you over age 65 and not accustomed to vigorous exercise?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Is there a good physical reason not mentioned here indicating why you should not follow an activity program even if you wanted to? |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you >20 lbs. over ideal body weight and not accustomed to exercise?   |

**\*\*\*IF YOU ANSWERED YES TO ANY OF THESE QUESTIONS YOU MUST GET A HEALTH SCREENING FROM YOUR PRIMARY CARE PHYSICIAN BEFORE BEGINNING THE CIVILIAN FITNESS PROGRAM OR ANY MODERATE TO VIGOROUS ACTIVITY.**

\*\*\* These medical questions are not designed to detect unfit individuals, but to identify and treat potential medical problems before they occur. The small number of problems that are identified are usually referred for further testing and, in many cases, a specifically designed exercise program is offered to provide good fitness training while preventing further complications.

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**HEALTH CARE PROVIDER APPROVAL FORM**

(This section may be signed by a Physician, Physician's Assistant, or Nurse Practitioner)

Patient name \_\_\_\_\_ Phone \_\_\_\_\_  
(print)

has medical approval to participate in the Civilian Fitness Program. I understand that the program includes mild to moderate intensity exercise, and may be conducted in unsupervised groups or individually. I also understand that participation is voluntary, allowing the participant to stop and rest at any time he or she desires.

The following restrictions apply (if none, so state):

Health Care Provider's Name \_\_\_\_\_

Office telephone number \_\_\_\_\_

Email address \_\_\_\_\_

Health Care Provider's Signature \_\_\_\_\_ Date \_\_\_\_\_

**CIVILIAN FITNESS PROGRAM****INFORMED CONSENT**

The undersigned hereby gives informed consent to engage in a series of health evaluations including an exercise test. The purpose of this test is to determine the undersigned's general physical fitness and health status. Exercise testing may be performed. Individuals trained in administration of the tests will conduct the voluntary Civilian Fitness Program Assessment. The assessment will include the following:

1. **Blood Pressure and Pulse.** A blood pressure cuff will determine **Blood Pressure**. Pulse will be determined by palpating the brachial artery in the wrist.
2. **Body Composition** will be determined by a variety of assessment methods:
  - **Body weight and height** will be measured on a standard medical scale.
  - **Body Fat Percent Testing** will be measured through use of a hand held machine.
3. **Cardiorespiratory Screening** will be done to provide an estimate of the cardiorespiratory fitness of the individual. Cardiorespiratory fitness is defined as the ability of the heart and lungs to provide oxygen to the muscles. The tests below are not valid nor should they be administered to individuals taking medications that affect heart rate. Cardiorespiratory screening will be done by using the 3-minute Step Test. The purpose of the Step Test is to measure the heart rate in the recovery period following three minutes of stepping. The results of the Step Test provide an indication of the cardiorespiratory fitness of the individual. The test is a tool that can be used to demonstrate an individual's progress during a training program. The recovery heart rate becomes lower, indicating a more efficient heart.
4. **The Sit and Reach Test** will be used as a screening device for measuring flexibility of the muscles in the back of the legs and trunk. Flexibility is defined as the range of possible movement in a joint or group of joints. The tester may stop the test if the individual experiences pain, fatigue, or other symptoms.
5. **Health Enrollment Assessment Review.** This is a health risk-screening tool that will be used to screen health risks. A computer analyzes the completed form and a Health Appraisal will be mailed to the undersigned at the address listed on the form.

The benefits of such testing are the scientific assessment of physical fitness and the appraisal of health hazards, which may facilitate prescription of my exercise and other lifestyle habits. I hereby give permission for use of aggregate data to be used for evaluation of the Civilian Fitness Program.

I realize participation is voluntary and I may withdraw from the Civilian Fitness program at any time at no prejudice to me. However, it is my responsibility to assure that I am officially dis-enrolled from the program by contacting the Health Promotion Coordinator. I am fully aware of the possible risks of personal injury, illness, and property damage loss associated with the activities in which I intend to participate, and acknowledge that I am assuming both the responsibility for safeguarding myself and my property as well as the risk of any injury, damage, or loss that may occur as a result of my participation.

There are numerous benefits to participation in the fitness program. I will have the opportunity to learn how to improve my diet, lose weight, manage stress, and how to exercise safely and effectively. Improving these health practices is thought to improve my overall health status and functional ability.

I have had my questions answered to my satisfaction regarding the Civilian Fitness Program. I understand that if I have additional questions, I may contact the Fitness Coordinator in my community.

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 (Signature)

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 (Date)

## CIVILIAN FITNESS PROGRAM



### HEALTH CARE PROVIDER REFERRAL FORM

Dear Health Care Provider,

Date:

Your patient, \_\_\_\_\_, desires to participate in the physical fitness component of the US Army Center for Health Promotion and Preventive Medicine (USACHPPM) "Targeting Health" Worksite Wellness Program. Our initial medical screening identified the following potential health risk factors:

- ☐ Age: 40 years or more (male), 50 years or more (female) with significant risk factors
- ☐ Elevated blood pressure: \_\_\_\_/\_\_\_\_mm/Hg, or on hypertension medication
- ☐ Smoking
- ☐ Diabetes
- ☐ Obesity
- ☐ Family history of cardiovascular disease in parents or siblings prior to age 55
- ☐ Symptoms or signs suggestive of cardiopulmonary disease
- ☐ Known cardiac, pulmonary, or metabolic disease
- ☐ Has not been recently (within 6 months) involved in a regular moderate exercise program

Other:

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Because of these risk factors, our guidelines require your patient to obtain clearance from you prior to participation in the Civilian Fitness Program. This program is provided and/or recommended by the Fitness Coordinator under the supervision of the Base Support Battalion and the USACHPPM-EUR staff.

Please complete the attached Health Care Provider Approval Form and return it to the patient listed above.

Sincerely,

Health Promotion Coordinator  
USACHPPM-EUR